Joan Walmsley, LCSW

GOAL ORIENTED, SOLUTION FOCUSED PSYCHOTHERAPY & COACHING

Informed Consent
Psychotherapy Services and Notice of Privacy Practices

Welcome! I will act within my professional capacity as a licensed social worker to merit your confidence and trust you have shown by coming in for assistance with your relationship concerns and personal difficulties. I would like to inform you about my policies and procedures.

Confidentiality

All sessions are confidential to persons outside of the therapy with some exceptions. I am required by law to report:

- Threats of harm to another or oneself
- Domestic violence
- Child or elder abuse
- By court order
- Per your signed release

In general, the HIPPA privacy rule gives individuals the right to request restriction and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications, and/or that a communication of PHI or disclosure be made by alternative means, such as sending a correspondence to the individual's office instead of the individual's home.

Therapy Process

You really do the work of therapy — I accompany you on the journey. I will discuss your goals for your therapy, and we will talk about the therapeutic process and approximate length of time needed. Sometimes, if not often, symptoms may get worse before they get better as change can sometimes require feelings of discomfort and other intense feelings. While therapy should end through mutual agreement once goals have been reached, you have the right to end therapy at any time. Please feel free to ask questions of me at any time

Financial Agreements

My hourly therapy fee is $200. Sessions normally last 45 minutes but occasionally can vary. For my conjoint sessions, 90 minutes may be recommended. If I am a provider for your insurance, you pay only your co-pay at each session and I will bill the rest for you.

Cancellation Policy

I know that emergencies and unplanned difficulties do happen. I ask only that you please cancel appointments with at least 24 hours advance notice; otherwise you will be charged the full fee. In the case of insurance, last minute cancellations will need to be paid in full by you as I cannot bill them for a "no-show."

Participation

This is to acknowledge that it is your choice to participate in therapy. You agree to take responsibility for your individual or part in your conjoint therapy and I will make a sincere effort to be prepared for your sessions. You agree to discuss termination prior to ending your therapy.

Your signature acknowledges agreement and understanding *(minors only: guardians must sign)*.

Print Name: ____

Signature: ____ Date: _______________________

Minors Only:

I myself, as the parent of ____, give permission to Joan Walmsley, LCSW to treat my child in Psychotherapy.

Print Name: ____

Signature: ____ Date: _______________________

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(714) 809-9944 | joanhwalmsley@yahoo.com

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New Patient Registration

Patient Information

Name: ____

Date of Birth: ___________ /___________ /___________

Insurance Information

Relationship to Patient: Self Guardian

Name: ____

Date of Birth: ___________ /___________ /___________

Mobile: (_________) ________________________ Messages may be left: Yes No

Office: (_________) ________________________ Messages may be left: Yes No

Home: (_________) ________________________ Messages may be left: Yes No

Home Address: ____

____

Employer: ____

Insurance Company: ____

Insurance I.D.#: ____

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